VI. Payment Assurance

The State shall pay each FQHC for services provided in accordance with the requirements of the Florida Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each FQHC according to the standards and methods set forth in the Florida Title XIX Federally Qualified Health Center Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of FQHC's in the Medicaid Program, the availability of FQHC services of high quality to recipients, and services which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204 (1992).

VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations.

IX. Payment in Full

Participation in the Program shall be limited to FQHC's which accept as payment in full for covered services the amount paid in accordance with the Florida Title XIX Federally Qualified Health Center Reimbursement Plan.

X. Definitions

A. Acceptable Cost Report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

B. AHCA - Agency for Health Care Administration, also known as the Agency.

C. Encounter - A face-to-face contact between a recipient and a health care professional who exercises independent judgment in the provision of health services to the individual recipient. For a health service to be defined as an encounter, the provision of the health service must be recorded in the recipient's record and completed on site. Categorically, encounters are:

1. Physician. An encounter between a physician and a recipient during which medical services are provided for the prevention, diagnosis, treatment, and rehabilitation of illness or injury.

2. Midlevel Practitioner. An encounter between a ARNP or a PA and a recipient when the ARNP or PA exercises independent judgement in providing health services.

3. Dental. An encounter between a dentist and a recipient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.

D. Interim Rate - A reimbursement rate that is calculated from budgeted cost data and is subject to cost settlement.

E. Cost Reporting Year - A 12-month period of operation based upon the provider's accounting year.

F. Eligible Medicaid Recipient - Any individual whom the agency, or the Social Security Administration on behalf of the agency, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the agency may make payments under the Medicaid program and is enrolled in the Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

G. HCFA-Pub. 15-1 - Also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Health Care Financing Administration. This manual details cost finding principles for institutional providers for Medicare and Medicaid reimbursement, and is incorporated by reference in Rule 59G-6.010, F.A.C.

H. HHS - Department of Health and Human Services

I. Rate Period - July 1 of a calendar year through June 30 of the next calendar year.

J. Title XVIII - The sections of the federal Social Security Act, 42 U.S.C.s 1395 et seq., and regulations thereunder, that authorize the Medicare program.

K. Title XIX - The sections of the federal Social Security Act, 42 U.S.C.s 1396 et seq., and regulations thereunder, that authorize the Medicaid program.

APPENDIX A

FLORIDA TITLE XIX FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) REIMBURSEMENT PLAN

CALCULATION OF INFLATION INDEX

1. An inflation index for FQHC's to be utilized in adjusting each FQHC's encounter rate for inflation is developed from the Data Resources, Inc.(DRI) Consumer Price Index (CPI)-All Urban (All Items) inflation indices. An example of the technique is detailed below. Assume the following DRI Quarterly Indices for the South Atlantic Region:

	1989	1990	1991	1992	1993
Q1	1.071	1.129	1.188	1.230	1.272
Q2	1.087	1.140	1.199	1.239	1.282
Q3	1.098	1.161	1.208	1.250	1.291
Q4	1.109	1.180	1.219	1.261	1.302

2. Based on the quarterly indices, monthly indices are calculated by averaging pairs of quarterly indices and interpolating between these averages as follows:

QUARTER	INDEX	AVERAGE INDEX	MONTH
1	1.071		
		1.079	MARCH 31
2	1.087		
		1.0925	JUNE 30
3	1.098		
		1.1035	SEPT. 30
4	1.109		

April 30 Index = (June 30 Index/March 31 Index)1/3 (March 31 Index)
= (1.0925/1.079)1/3 (1.079)
= 1.084

May 31 Index = (June 30 Index/March 31 Index)2/3 (March 31 Index)
= (1.0925/1.079)2/3 (1.079)
= 1.088

All other monthly indices can be calculated in a similar fashion. To determine the applicable inflation factor for a given FQHC for the rate period July 1, 1991, the index for December 31, 1991, the midpoint of the rate period, is divided by the index for the midpoint of the Provider's Fiscal Year. For example, if an FQHC has a fiscal year end of November 30, 1990 then its midpoint is May 31, and the applicable inflation is:

December 1991 Index/May 1990 Index(1.2245/1.20016)
= 1.02028

Therefore, the FQHC's Medicaid encounter rate as established by the cost report is multiplied by 1.02028 to obtain the prospectively determined rate for the rate period July 1, 1991 through June 30, 1992.

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FLORIDA TITLE XIX COUNTY PUBLIC HEALTH UNIT

REIMBURSEMENT PLAN

VERSION II

EFFECTIVE DATE: JANUARY 1, 1994

I. Cost Finding and Cost Reporting

A. Each County Public Health Unit (CPHU) participating in the Florida Medicaid CPHU Program shall submit a cost report postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. Four complete, legible copies of the cost report shall be submitted to AHCA.

B. Cost reports available to AHCA pursuant to Section IV, shall be used to initiate this plan.

C. Each CPHU is required to detail costs for it's entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. A prospective reimbursement rate, however, shall not be established for a CPHU based on a cost report for a period less than 12 months. Interim rates shall be cost settled for the interim rate period.

D. The cost report shall be prepared in accordance with the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413, and further interpreted by the Provider Reimbursement Manual (HCFA-Pub. 15-1 as incorporated by reference in

Rule 59G-6.010, F.A.C.) except as modified by this plan.

E. Each CPHU shall file a legible and complete cost report within 3 months, or 4 months if a certified report is being filed, after the close of its reporting period.

F. If a CPHU provider submits a cost report late, after the 90 day period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been submitted within 3 months, then the CPHU provider's rate for that rate period shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effective retroactively. A CPHU which does not file a legible and complete cost report within 6 calendar months after the close of its reporting period shall have its provider agreement cancelled.

G. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60 (1992). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

II. Audits

All cost reports and related documents submitted by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General.

1. Primary responsibility for the audit of providers shall be borne by AHCA. AHCA audit staff may enter into contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 (1992) are met.

2. All audits shall be performed in accordance with generally accepted auditing standards as incorporated by reference in Rule 21A-20.008,(4-21-91), F.A.C. of the American Institute of Certified Public Accountants (AICPA).

3. The auditor shall issue an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all Federal and State regulations pertaining to the reimbursement program for CPHUs. All reports shall be retained by AHCA for 3 years.

B. Retention

All audit reports issued by AHCA shall be kept in accordance with 45 CFR 205.60 (1992).

C. Overpayments and Underpayments

1. Any overpayments or underpayments for those years or partial years as determined by desk or field audits, using approved State plans, shall be reimbursable to the provider or to AHCA as appropriate.

2. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either

reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.

3. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.

4. The terms of repayments shall be in accordance with Section 409.902, Florida Statutes.

5. All overpayments shall be reported by AHCA to HHS as required.

6. Information intentionally misrepresented by a CPHU in the cost report shall result in a suspension from the Florida Medicaid Program.

D. Appeals

For audits conducted by AHCA a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 59-1.021, Florida Administrative Code (F.A.C.), and Section 120.57, Florida Statutes, for any or all adjustments made by AHCA.

III. Allowable Costs

Allowable costs for purposes of computing the encounter rate shall be determined using Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413 (1992), and the guidelines in the Provider Reimbursement Manual (HCFA-Pub. 15-1 as incorporated by reference in Rule